EI Services Subcommittee
2-12-09

Present: Stephen Olson, Jim Carter, Suzy Heise, Jill Staudinger, Deb Balsdon, Kimm Sickler, Margaret LoMurray, Roxane Romanick, Carol Johnson, Kristen Votava

Suzy moved to accept minutes, Jim Carter seconded. Minutes were approved.

Deb noted that there was one correction to the training schedule: RBI training date is April 22nd, not April 12th.

Discussion about the EI Competencies Work Group:
Question: How would you decide on the competency of a person? Deb responded by noting that there be will an ongoing list of who is competent in what area. It appears now that the competency determination will be made at the local level. Deb gave the example of the RBI training as one example of RBI competency.

Discussion about the NLO Work Group – Roxane discussed what is happening since the last time we met – outlined family story and NECTAC presentation.
Roxane noted that the group was asked to help us come up with activities to supplement the work plan – what details actually need to happen – looking for volunteers – refining the work plan and moving forward. No further questions about the work group

MR-DD Waiver Changes – An initial Medicaid waiver is approved for 3 years, ongoing waivers are approved for 5 years. They are "restarting" the MR-DD waiver on April 1, 2009. The self-directed support waivers have been collapsed into one so the approval process is for both the traditional waiver and the self-directed waiver. The state office wants them to be approved by 4-1-09. The waiver applications were out for public comment and then the waiver proposal was submitted. The main changes affecting children is the fact that DD Case Management will not be an approved service in and of itself. Case Management will be an administrative service, not a waiver service. If we kept DDCM in the waiver, we would have to open this service up to the public sector so that families could have a choice. The state would still need a service to screen and approve persons into the waiver.

For children receiving DDCM only, they will need to be de-screened if they don't have an additional waiver service. Starting April 1st, excess medical costs (i.e. those covered under Family Subsidy) can be now considered a waiver service.
Clarification: this will only affect children 3 and above that are getting DDCM only.
Reply: There are some children under 3 that this applies to as well. Reply: In-home supports have always been part of the waiver.
Recommendations from the subcommittee: Notify families as soon as possible, want a face-to-face visit with someone versus getting a letter, make sure what other resources

there are, checking on when their Medicaid is up and what other options for MA, Other resources: Healthy Steps, Caring Program, Children with Disabilities, Prescription Drug Plans, A phone number for their eligibility worker, SSI process, Family Voices.

Children can still be eligible for and receive DDCM even though they can't be screened for waiver.

DD Case Managers will be called DD Program Managers.

There are questions in the Family Support Application about who needs a specially trained caregiver in the state. This continues to be an area where there is subjectivity. Deb noted that there is always difficulty between making determinations between want and need. This is the work that DDCM must do in making these determinations.

We have started DDCM and Family Subsidy when a child is in the hospital (NICU or new hospitalization). We are no longer going to be able to offer services when someone is hospitalized. Offering up that we are not going to be offering services during hospitalization. A concern was noted about the effect on children who are on the waiver and then need hospitalization – how long can they be in hospital before they are dropped from the waiver? An example was provided about a situation where the ID person was the primary support to the family and the child was in and out of the hospital. Deb noted she is continuing to tryto define the length of time of hospitalization that CMS would agree to – right now they are saying there is a zero tolerance. Recommendations: DDCM need more training on how to work with families – some regions are already solely working with families (not referring to ID until they are home) – May need some training on emotional supports and parent education. Will need to consider the intensity of need – Also consider EP's supports – some training with discharge folks in the hospitals. Need to connect with the discharge staff.

Deb also outlined newly added Parent Support component. This program is based on the parents need to for parenting support not the child's need for intervention.

The new waiver application allows an extension of home health care. There is presently a cap on the home health (can't exceed the average cost of a NH bed) through the state plan. The waiver would allow home health care to continue.

Behavioral consultation is added to the waiver.

Prioritization:

The subcommittee was presented with a list of work jobs that the state office presently has pending. Below is the list and a summary of the discussion. Only a portion of the list was reviewed due to time.

North Dakota Early Intervention
State Work Tasks
February, 2009

Statewide Monitoring Activities

- Federal reports – Office of Special Education and Centers for Medicare and Medicaid
- Regional feedback
- **RICC function – discussion about using the RICC to discuss the quality improvement plans. Rec: meet less frequently and give them a specific agenda from the NDICC – rather than them coming up with their own agenda items.

Data Collection

- ASSIST Changes/Changes to the state system data-based system
- Revision to the Case Review Tool
- **Changes to Statewide Family Survey – web-based access
- **Initiation of the Statewide Transition Follow-up Survey
- Staff Training:
  - Quality Enhancement Reviews, Child PAR, ASSIST
- 618 Reports – Office of Special Education requirement
- Annual Performance Report and SPP needs
- **Right Track database – rec: change the contract, do not need to use the current RT system until a new system is developed. Discussion: This is difficult to prioritize at this time. We are able to collect data off the billing system. (how many children are seen? What percentage of referrals are from RT? What percent of the population was seen?) Regions have their own databases. Question: Is there a need statewide for certain data sets? Is there cost saving? Rec: This should remain a long-term goal.

Hearing Screening Implementation – rec: that this needs to be a priority

- Equipment installed
- Audiology contracts
- Data collection systems
- Need for continued training and procedure review

Infant Development Rate Methodology

- Assuring adequate funding and distribution of funding to support a trans-disciplinary, primary service provider model.
- Access consultation

State Competency System

- Ongoing development work
- Administrative Code changes
- Staff Training

Child and Family Intervention Support – rec: assuring that we are considerate of staff needs for flexibility and easy access through use of technology

- Ongoing Routine Based Interviewing Training
- Trans-disciplinary Coaching Model Training
- Training for foster care families
- Development of a mentoring system
- Monthly statewide training on various topics.

ND EI Technical Assistance

ND EI Public Information Materials Development
- Develop statement on service delivery model
- Contract with developer

Maintenance of the North Dakota Interagency Coordinating Council

Transition
- Follow-up Family survey
- Common data warehouse with DPI

Childfind
- Right Track Data Base
- Training for Referral sources, Early Head Start and Child Care Resource and Referral
- Tribal Social Service Memorandum of Understanding

Roxane will send out a survey monkey to determine next meeting date and time.